Find help with the cost of medicine

Thank you for downloading this prescription assistance document from NeedyMeds. We hope this program will help you get the medicine you need.

REMEMBER — Send your completed application to the address on the form, NOT to NeedyMeds.

Did you know that NeedyMeds has thousands of other free resources?

Here's a look at more ways we can help you save money on medicine and healthcare costs. Each one can be found under the **"Healthcare Savings"** tab on our website:

- **Diagnosis-Based Assistance** — NeedyMeds lists thousands of assistance programs for almost any health condition. If you are going through chemo treatment for cancer, there are programs that can help with wig costs and scalp-cooling products. We also list resources for free diabetes testing supplies, caregiver lodging support, and much more.
- **Free, Low-Cost, and Sliding Scale Clinics** — This popular collection contains information on 18,000+ free, low-cost, and sliding scale medical, dental, mental health and substance abuse clinics across the U.S. It's a great resource if you need affordable medical treatment and don't know where to go.
- **Coupons, Rebates & More** — You can use the NeedyMeds website to find 2,600+ cost-saving opportunities for both prescription and over-the-counter drugs and medical supplies.
- **Medical Transportation** — Need help getting to the doctor's office or medical facility? You may be eligible for financial assistance if you meet certain requirements.

NeedyMeds also offers information on diagnosis-based camps and retreats, recreational programs, scholarships, government programs, $4 generic drug programs, and more.

Finally, I want to tell you about the NeedyMeds Drug Discount Card. Thousands of people use this free, anonymous, and easy-to-use tool to get the best price on their medications. Use the card to get discounts on lab tests and also to save 40% on durable medical equipment. To date, our drug discount card has saved patients over $300,000,000. Check out the following page to learn more.

Feel free to call our toll-free helpline if you have any questions. We can be reached at 1-800-503-6897 Monday-Friday, 9am-5pm Eastern Time.

Thank you for using NeedyMeds. Please let us know if we can do anything else to help you afford the costs of your healthcare.

Rich Sagall, MD
President, NeedyMeds

NeedyMeds.org
50 Whittemore St.
Gloucester, MA 01930

Helpline: 1-800-503-6897
Email: info@needymeds.org

www.needymeds.org

Clip the card and save

DRUG DISCOUNT CARD

BIN: 020750
RX PCN: NMeds
RX GRP: PDFPDF
ID: NMNA019309901930

Customer Care
1-888-602-2978

This is a drug discount program, not an insurance plan.

NeedyMeds Drug Discount Card
www.needymeds.org

Patient: You may use this card at any of over 65,000 participating pharmacies to save on all prescription medicines. You cannot use this card with Medicare including part D, Medicaid, or any other state or federal programs unless you choose not to use your government-sponsored program. In addition, you cannot use this card with any health insurance program, but you can use it in place of your insurance if the card offers a better price. For questions call 1-888-602-2978 or visit www.drugdiscountcardinfo.com.

Pharmacist: Administered by Medical Security Company, LLC, Tucson, AZ.

Pharmacy Help Desk: 1-800-404-1031.

Powered by ScriptSave® WellRx

- Save up to 80% on medications*
- Use at over 65,000 pharmacies nationwide including all major chains
- Share the card with friends and family
- Use the card as often as needed
- Free, no fees or registration
- Never expires

What will receive a discount?

All prescription medications are eligible for savings, including over-the-counter medicines and medical supplies written as a prescription, as well as human-equivalent pet medications with a prescription by a veterinarian.

Save up to 40% off durable medical equipment, including canes, crutches, splints, incontinence supplies and more. You can also save on diabetic supplies such as glucose meters, test strips, lancets and diabetic shoes. Visit www.needymeds.org/dme to learn more.

You can also save an extra 5% on affordable lab tests and online results. No doctor's order or insurance needed. Visit www.needymeds.org/L2L for more information.

What if I have insurance?

Anyone can use the card, but it can't be combined with state or federal insurance. You can use the card instead of insurance if:

- A drug isn't covered by your insurance
- Your insurance has no drug coverage
- You have a high drug deductible
- You have met a low medicine cap
- The card offers a better price than your copay
- You are in the Medicare Part D donut hole

To obtain a plastic drug discount card, send a self-addressed, stamped envelope to:

NeedyMeds Drug Discount Card
50 Whittemore St.
Gloucester, MA 01930

The card is not valid in combination with insurance plans, including Medicare, Medicaid or any state or federal prescription insurance. The card can be used only if you decide not to use your government-sponsored drug plan for your purchases.

* Average savings of 60%, with potential savings of up to 80% or more (based on 2018 national program savings data). All prescription medications are eligible for savings.

This is a drug discount program, not an insurance plan. Discounts are available exclusively through participating pharmacies. The range of the discounts will vary depending on the type of prescription and the pharmacy chosen. This program does not make payments directly to pharmacies. Users are required to pay for all prescription purchases. Cannot be used in conjunction with insurance. You may call 1-888-602-2978 with questions or concerns or to obtain further information.

ViiVConnect Enrollment Form

ViiVConnect provides comprehensive information on access and coverage to help patients get their prescribed ViiV Healthcare medications.
There are 4 ways to enroll a patient:

- Complete and fax this form to 1-844-208-7676
- Via the online portal at www.viivconnect.com — For HCPs and Patient Designated Representatives
- Talk one-on-one live with a dedicated Access Coordinator at 1-844-588-3288
- Complete and mail this form to ViiVConnect Enrollment PO Box 220100 Charlotte, NC 28222-0100

PATIENT INFORMATION (REQUIRED)				
First Name:	MI:	Last Name:		
Preferred Phone:	Street:			
DOB:	City:	State:	ZIP:	Sex: Male Female

INSURANCE INFORMATION - INSURED PATIENTS (Include scanned copies of the front and back of all insurance cards, including medical and prescription)	
Primary Insurance Name:	Policyholder Name:
Primary Insurance Phone:	Policyholder DOB:
Policy ID #: Group #:	Policyholder Relationship to Patient:
Subscriber Name:	Policyholder Phone:

VIIV HEALTHCARE MEDICATION PRESCRIBED (REQUIRED)	
Product Name:	Dosage (mg):

PRESCRIBER INFORMATION (REQUIRED)	
Prescriber's First/Last Name:	Office Contact Name:
Practice Name:	Street:
Phone: Fax:	City: State: ZIP:
Prescriber Tax ID:	Prescriber NPI #:
Prescriber State License #:	Group NPI #:
Patient Diagnosis and ICD-9/ICD-10 Code:	

PATIENT ASSISTANCE PROGRAM (PAP) - (Complete only if applying for medication at no cost for eligible patients) Prescription must accompany form.	
List any known drug allergies:	Check box if none
List any known health conditions:	Check box if none
Number of people living in household who contribute to or are dependent on your household income:	
Social Security Number (SSN)*:	Total Gross Annual Income:
1. Is the patient eligible for any state or federal prescription drug coverage plan such as Medicaid or Puerto Rico's Government Healthcare Program, Mi Salud?	Yes No
2. Does the patient have any private prescription drug coverage (including employer-sponsored plans, private group plans, marketplace plans/exchanges, etc)? • If "yes," please indicate why assistance is needed:	Yes No
3. What is the ADAP status of the patient?	Denied Wait-listed Pending Not Applied/Not Eligible
4. Is the patient enrolled in a Medicare Part B, Medicare Part D, or Medicare Advantage prescription drug plan?	Yes No
5. If "yes" to question 4, has the patient spent at least $600 or more on prescription expenses since January 1st of the current calendar year? • If "yes," please scan an explanation of benefits or pharmacy receipt(s) indicating the patient paid a total of at least $600 for prescriptions in the current calendar year. Note: Medicare Part B, Medicare Part D, and Medicare Advantage patients cannot enroll by phone.	Yes No

SHIPPING ADDRESS (Complete only if applying for the Patient Assistance Program and the medication should be shipped to an address other than the patient address at top of page)			
Medication will be shipped to: Addressee or Business Name:			
Street:	City:	State:	ZIP:
Specify addressee's relationship to the applicant: Physician Patient Designated Representative (must complete Patient Designated Representative information on page 2) Other (specify relationship):			

*If you do not have an SSN or you are unable to provide it, please note that income documentation may be required to review program eligibility.

Form continued on the following page.

Downloaded from NeedyMeds.org

PATIENT AUTHORIZATION AND RELEASE

I certify that the information provided within this Enrollment Form and Patient Authorization and Release is true and correct. I understand that the collection, use, and disclosure of certain information is protected under law. I understand that Information contained in this Enrollment Form, such as my name, address, insurance, prescription, and medical information, is "Protected Health Information." By signing below, I agree to the collection, use, and disclosure of my Protected Health Information as described below. I understand that my healthcare providers will not base any medical treatment decisions on my agreement to sign this Patient Authorization and Release. I also understand that my agreement to sign this Patient Authorization and Release and enroll in ViiVConnect is not required for my valid prescription to be filled. I understand that once Protected Health Information is collected, used, and/or disclosed based on this executed authorization, federal privacy laws may not prevent the entities described below from further disclosing my information. However, I understand that such entities have agreed to collect, use, or disclose Protected Health Information received only for the purposes described in this authorization or as required by law. I understand that ViiV Healthcare does not charge a fee for participation in ViiVConnect programs. If my authorized Patient Representative charges a fee for enrollment or refills of my free medicine received under the Patient Assistance Program, this money is not paid by or paid to ViiV Healthcare. I certify that any product that I receive from ViiV Healthcare is for my own use and will not be sold, bartered, or given to any other person. I certify that the information provided in this Enrollment Form is complete and accurate to the best of my knowledge and agree to notify ViiVConnect of any change in my insurance eligibility or financial status. I understand that this authorization will remain in effect for two (2) years, unless a shorter time period is mandated by state law. I also understand that I have the right to revoke this authorization at any time by calling 1-844-588-3288 or mailing a signed, written statement of my revocation to ViiVConnect, PO Box 220100, Charlotte, NC 28222-0100, but that such a revocation would end my eligibility to participate in the programs as described. Upon receipt and processing of written revocation of this authorization, further disclosures of Protected Health Information will be prohibited. However, certain information may still be collected, used, and disclosed for administrative purposes by ViiV Healthcare and any other companies that ViiV Healthcare uses to collect, use, and disclose such information.

Enrollment in ViiVConnect: The Patient and, if applicable, the Patient Representative MUST sign this Patient Authorization and Release. Patient Representative must define their relationship to the Patient in the designated box below.

By signing this Patient Authorization and Release, I authorize ViiV Healthcare and any other companies that ViiV Healthcare uses to collect, use, or disclose my Protected Health Information to do the following:

1. Request and receive from my doctor, healthcare provider, health insurer, or pharmacist information necessary to investigate and resolve my insurance coverage, coding, or reimbursement inquiry, or review my eligibility for Patient assistance programs and co-pay assistance.
2. Collect, use, and disclose to each other any information that I provide to ViiVConnect for investigating and resolving my insurance coverage, coding, or reimbursement inquiry.
3. Disclose to my treating physician, healthcare provider, or pharmacist information I provide to ViiVConnect when necessary to resolve my insurance coverage, coding, or reimbursement inquiry. I also authorize my insurer, doctor, healthcare provider, and pharmacist to release information about my prescribed medications and medical condition requested by ViiVConnect.
4. Contact my insurer, other potential funding sources, social workers, Patient advocacy organizations, and/or Patient assistance programs on my behalf to determine if I am eligible for health insurance coverage or other funds and disclose to them information about my prescribed medications and medical condition that has been provided to ViiVConnect by me or my physician, healthcare provider, or pharmacist.
5. Disclose any information obtained from the sources listed above to third parties if required by law.
6. Request additional documents and information at any time, even if I am already enrolled so that ViiV Healthcare can determine if the information on this form is complete and true.

Downloaded from NeedyMeds.org

PATIENT AUTHORIZATION AND RELEASE (SIGNATURE REQUIRED)

If applicable, I authorize a Patient Representative to act on my behalf pursuant to the Patient Representative Certification below.			Yes	No*
I authorize ViiVConnect to provide me with information on my benefits and other communications that contain reference to ViiVConnect through the following:	Phone	Text	Email	Any
If I am unavailable when contacted, I authorize ViiVConnect to leave a voicemail with the Access Coordinator's name, a reference to ViiVConnect, and a call back phone number.			Yes	No*

If I do not authorize ViiVConnect to leave a voicemail with the Access Coordinator's name, a reference to ViiVConnect, and a call back phone number, I will be responsible for contacting ViiVConnect.

Patient (REQUIRED)	**Name (please print):**
Signature:	
Date:	

Patient Representative†	**Name (please print):**
Signature (stamped signature not accepted):	
Date:	
Relationship to Patient:	

PATIENT REPRESENTATIVE CERTIFICATION
By my signature, I certify to the best of my knowledge that the information on this Enrollment Form is correct and complete. I have no knowledge of any intent to sell, barter, or give any free medicine received under the Patient Assistance Program to any person other than the Patient for whom it has been prescribed. To the best of my knowledge, the information about the Patient on this Enrollment Form is complete. I acknowledge that the programs through ViiVConnect do not constitute health insurance. My signature above also serves as attestation that the Patient has authorized me to act on their behalf. As the Patient's Representative, I authorize ViiV Healthcare and any other companies that ViiV Healthcare uses to collect, use, and disclose the Patient's information. I also understand that I have the right to revoke this authorization on behalf of the Patient at any time by calling 1-844-588-3288 or mailing a signed, written statement of my revocation to ViiVConnect, PO Box 220100, Charlotte, NC 28222-0100, but that such a revocation would end my eligibility to participate in the programs as described. Upon receipt and processing of written revocation of this authorization, further disclosures of Protected Health Information will be prohibited. However, certain information may still be collected, used, and disclosed for administrative purposes by ViiV Healthcare or any other companies that ViiV Healthcare uses to collect, use, or disclose such information.

Complete, sign, and electronically submit all pages of this form and applicable corresponding documents (including the prescription) through the portal, or fax to 1-844-208-7676 (toll-free).

For assistance, please call 1-844-588-3288 (toll-free), Monday through Friday, 8 AM to 11 PM ET.

†Only complete this section if the Patient Representative enrolls the Patient and wants to be the contact person and receive program correspondence on behalf of the Patient.

Trademarks are owned by or licensed to the ViiV Healthcare group of companies.

©2020 ViiV Healthcare or licensor. ADR 2020.01 VC Enrollment Form English (Digital) 1001 January 2020 Produced in USA.

ViiVConnect